COUNTY OF LOS ANGELES
OFFICE OF THE COUNTY COUNSEL

648 KENNETH HAHN HALL OF ADMINISTRATION
500 WEST TEMPLE STREET
LOS ANGELES, CALIFORNIA 90012-2713

RAYMOND G. FORTNER, JR.
County Counsel

TELEPHONE
(213) 974-1838
FACSIMILE
(213) 626-7446
TDD
(213) 633-0901
E-MAIL
Jkrattli@counsel.lacounty.gov

July 16, 2008

TO: SACHI A. HAMAI
Executive Officer
Board of Supervisors

Attention: Robin Guerrero
Deputy Executive Officer
Board Operations

FROM: JOHN F. KRATTLI
Senior Assistant County Counsel

RE: **Eva Loza and Griselda Maldonado v. County of Los Angeles**
Los Angeles Superior Court Case No. BC 354 078

Attached is the Agenda entry for the Los Angeles County Claims Board's recommendation in the above-referenced matter.

It is requested that this recommendation, the Case Summary, and the Summary Corrective Action Plan be placed on the Board of Supervisors' agenda for July 29, 2008.

JFK:rfm

Attachments

HOA.534023.1

Board Agenda

MISCELLANEOUS COMMUNICATIONS

Los Angeles County Claims Board's recommendation: Authorize settlement of the matter entitled Eva Loza and Griselda Maldonado v. County of Los Angeles, LASC Case No. BC 354 078, in the amount of $762,500, plus the assumption of a Medi-Cal lien in the amount of $226,237, and instruct the Auditor-Controller to draw a warrant to implement this settlement from the Department of Health Services' budget.

This medical negligence lawsuit arises from treatment received by a patient while hospitalized at LAC+USC Medical Center.

CASE SUMMARY

INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

CASE NAME	Eva Loza and Griselda Maldonado v. County of Los Angeles
CASE NUMBER	BC 354078
COURT	Los Angeles Superior Court Central District
DATE FILED	June 30, 2006
COUNTY DEPARTMENT	Department of Health Services
PROPOSED SETTLEMENT AMOUNT	$762,500, plus the assumption of Medi-Cal lien in the amount of $226,327.
ATTORNEY FOR PLAINTIFF	Philip Michels, Esq.
COUNTY COUNSEL ATTORNEY	Richard Mason
NATURE OF CASE	This is a medical malpractice case brought by Eva Loza and her mother, Griselda Maldonado, for the injuries that they suffered while Griselda Maldonado was giving birth to her daughter, Eva Loza, at LAC+USC Medical Center. On July 4, 2005, Griselda Maldonado was taken to the delivery room at LAC+USC Medical Center to deliver her infant. Due to the size of the infant's abdomen, the delivery process became

complicated. To assist the process of infant's delivery, the LAC+USC staff had to apply various obstetrical maneuvers, during which, the infant suffered injury to her arms.

Both Ms. Maldonado and her daughter Eva Loza brought a lawsuit against the County of Los Angeles contending that the LAC+USC staff were negligent when providing care to the plaintiffs.

Although the County will assert that the proper medical treatment was provided to the plaintiffs, considering the risks involved in a jury trial, including the potential exposure in this case, the Department of Health Services agreed to propose a settlement of this case in the amount of $762,500, plus the assumption of Medi-Cal lien in the amount of $226,327.

PAID ATTORNEY FEES, TO DATE	$58,045
PAID COSTS, TO DATE	$49,962

Summary Corrective Action Plan

Date of incident/event:	July 4, 2005
Briefly provide a description of the incident/event:	Griselda Maldonado presented to LAC+USC Medical Center for delivery of a baby with abdominal ascites (fluid in the abdomen). The plan was for the attending physician to be present for the delivery, however when Ms. Maldonado was ready to deliver, the attending physician was performing a cesarean section on another patient. Although the nurse midwife notified the attending physician of the impending delivery, there was a miscommunication between them. The attending physician did not realize it was Ms. Maldonado that was ready to deliver. The nurse midwife encountered difficulties with the delivery resulting in the baby's right arm weakness. The baby also has developmental delays that have not been determined to be related to the birth.

1. Briefly describe the root cause of the claim/lawsuit:

Inadequate communication of the plan of delivery

2. Briefly describe recommended corrective actions:
(Include each corrective action, due date, responsible party, and any disciplinary actions if appropriate)

- On July 2005, re-education of nursing staff on communication during emergency situations was held during staff meetings.
- On January 19, 2006 and October 28, 2007, Obstetric Emergency Drills were held.
- On May 18, 2007, a Noelle Simulator (Training system with manikin) was implemented. *A Noelle Obstetric simulator is computerized manikin that is programmed with multiple obstetrical and neonatal emergency or case scenarios including shoulder dystocia.*
- On May 25, 2007, the Obstetrics Faculty and house staff were educated on SBAR communication during Grand Rounds.

3. State if the corrective actions are applicable to only your department or other County departments:
(If unsure, please contact the Chief Executive Office Risk Management Branch for assistance)

☐ Potentially has County-wide implications.

X Potentially has implications to other departments (i.e., all human services, all safety departments, or one or more other departments).

☐ Does not appear to have County-wide or other department implications.

Signature: (Risk Management Coordinator)	Date: 6/26/08
Signature: (Department Head)	Date: 6-26-08

6/30/08